DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 241-2345 To Report Adult Abuse: (800) 564-1612

Fax (802) 241-2358

August 19, 2011

Ms. Meagan Buckley, Administrator Berlin Health & Rehab Ctr 98 Hospitality Drive Barre, VT 05641

Provider ID#: 475020

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on July 20, 2011. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

laMCotaPN

PC:ne



AUG-U4-ZUll THU U3:13 PM LICENSING AND PROTECTION

FAX NO. 8022412358

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Division of

PRINTED: 08/04/2011 FORM APPROVED

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO 0938-0391 BENTERO FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA O(3) DATE SURVEY (XX) MULTIPLE CONSTRUCTION Protection AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 475020 07/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BERLIN HEALTH & REHAB CTR BARRE, VT 05041 SUMMARY STATEMENT OF DEPICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG TAG DEFICIENCY F 000 **INITIAL COMMENTS** E 000 An unannounced onsite recertification survey and complaint investigation were conducted by the Division of Licensing and Protection from 7/18/11 to 7/20/11. The following regulatory deficiencles were cited. Corrective action: 483.15(b) SELF-DETERMINATION - RIGHT TO F 242 F 242 F 242 MAKE CHOICES 1. Resident #183 evaluated and no SS=D negative outcome resulted from The resident has the right to choose activities, this alleged deficient practice. schedules, and health oare consistent with his or 2. Meal tray nicket error was her interests, assessments, and plans of care: corrected and dietary preferences interact with members of the community both reviewed and updated on care plan. inside and outside the facility; and make choices 3. All residents with special diets and about aspects of his or her life in the facility that allergies are at risk. are significant to the resident. 4. Dietary to ensure special restrictions and allergies are identified and followed. This REQUIREMENT is not met as evidenced 5. Re-educate dictary staff on diet by: tray card accuracy. Based on observation, resident and staff 6. Random weekly audits to be interview, and review of the medical record, the performed by Dietary Manager or facility falled to honor the food preferences and designee to determine continued medical food restrictions of 1 of 17 residents in compliance with plan. the Stage II sample (Resident #183). Findings 7. Dietary Manager shall report out to include: OAA committee monthly x3 at this On 7/18/11 at 2:05 PM during the Stage I resident time frequency of further screening Interview, Resident #183 indicated that surveillance shall be determined by s/he does not receive the food s/he prefers on committee. his/her meal tray and that his/her distary Corrective actions shall be restrictions are not honored. Per observation of complete by 8/20/2011 the meal service at 5:00 PM on 7/18/11, Resident #183's tray contained a ham salad sandwich on white bread, mashed potatoes, tomato soup, a cookie, coffee, creamer, sugar, a packet of ketchup, tea and a mighty shake. The dietary tag on the residents tray Indicated the tray contained

LABORATOR IDIRECTOR'S OR PROVIDER SUPPLIES REPRESENTATIVE'S SIGNATURE

TITLE aministra (XII) DA'TE

Any deficiency statement ending with an exterior (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosuble 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG-U4-2011 THU U3:14 PM LICENSING AND PROTECTION

FAX NO. 8022412358

P. U4/16

		AND HUMAN SERVICES				FORM	08/04/2011 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROMOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE 91 COMPLE	JRVEY
		475020	B. WIN	1G_		07/2	0/2011
NAME OF P	ROVIDER OR SUPPLIER			•	IEET ADDRESS, CITY, STATE, ZIP CODE		
BERLINI	HEALTH & REHAB C	TR		88 HOSPITALITY DRIVE BARRE, VT 05641			
(X4) ID PREFIX TAG	(EAGH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG		FROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION BHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(AR) COMPLETION DATE
F 242	a cheeseburger, fre soup, tea, sugar, ki shake. The dietary resident likes whole cottage cheese and	ge 1 ench fries, chicken noodle etchup, a cookie and a mighty tag also indicated that the wheat bread, fruit and is also indicated that the have any tomato products.	F:	242			
	Resident #183 has surgical repair of a (gastroesophageal nutritional care plan	cal record Indicated that medical diagnoses of recent hiatal hernia and GERD reflux disease). Review of the dated 5/23/11, Resident #183 natoes and pineapple.		l	F242 POC acce Karen lamp	pted vo Ra	8/18/1))
F 279 59=0	Dietary Service Ma Registered Dieticia menu and substitut chicken noodle. The salad sandwich and utilized for Resider consistency of med indicated that the littoket when placing tray. The RD, DSM confirmed the pote medical issuas from dietary restrictions 483.20(d), 483.20(k)(1) DEVELOP	F	279			
	A facility must use to develop, review comprehensive pla	the results of the assessment and revise the resident's n of care.				-	
	plan for each resid	evelop a comprehensive care ent that includes measurable stables to meat a resident's					

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FAX NO. 8022412358

P. 05/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/04/2011 FORM APPROVED OMB NO. 0038 0304

CENTE	SE COR MEDICARE	S-MEDICAID DERVICES			- OMB-NO	9038 0304
STATEMEN	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIN	PLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
		475020	B. WING		07/20/2011	
	ROVIDER OR SUPPLIER HEALTH & REHAB C	TR	B	EET ADDRESS, CITY, STATE, ZIP CODE 8 HOSPITALITY DRIVE IARRE, VT 05841		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INPORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 279	medical, nursing, a needs that are ider assessment. The care plan musto be furnished to a highest practicable psychosocial well-lights and any aborequired under due to the resident §483.10, including under §483.10(b)(4). This REQUIREME by: Based on observativew, the facility comprehensive canddress all identifications.	Ind mental and psychosocial ntified in the comprehensive at describe the services that are attain or maintain the resident's ephysical, mental, and pelng as required under services that would otherwise §483.25 but are not provided the right to refuse treatment	F 279	Corrective action: F 279 1. Resident #129 evalual continues to prefer to "jonny" at times and assistance with self continues to income this alleged deficient 2. Comprehensive care proceed on 7/19/20 3. All residents needing comprehensives care risk. 4. Nursing department to comprehensive care proceed timely by the comprehensive care proceed timely by the comprehensive care proceed to the comprehensive care pro	wear a refuses are elements resulted from practice. plan was 011. a plan are at 0 ensure blans are 8/20/2010. agers of blans. ts to be of Nursing	D
	chart had an initial 06/27/11 that listed to not individualized a regarding preferen grooming (assistantiamily member precomprehensive as 07/07/11 which ide for the highest levidislikes, such as five resident was noted	on 07/19/11, Resident #129's Interim care plan dated digeneral categories of care but approaches for the resident aces/needs for dressing and for nee with shaving) and to have esent for physician visits. The assement was completed on entified the resident's objectives all of functioning, likes and amily notification and dressing, uring the 3 days of survey the discharge only a johnny shirt of was unshaven. Per interview		or designee to determ compliance with plan 7. Director of Nursing of shall report out to QA monthly x3 at this tire of further surveillance determined by commit 8. Corrective actions shall complete by 8/20/201 F379 PDC acceptions Campatal Campat	r designee A committee e frequency e shall be ittee. Il be	e

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P. 06/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

PRINTED: 08/04/2011 FORM APPROVED OMB NO: 0000-0004

	of Deficiencies of Correction	(X1) PROVIDER/SUPFLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
		475020	B. WING _		07/2	0/2011
	ROVIDER OR SUPPLIER HEALTH & REHAB C	דת	98	EET ADDRESS, CITY, STATE, ZIP CO B HOSPITALITY DRIVE ARRE, VT 05641	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S FLAN OF CO (PACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N BHOULD BE	(X6) COMPLETION DATE
F 279 F 281 SS=D	"I was never told the until yesterday but I [Resident #129] ne anywhere that much The family member not alert her that [Rurologist yesterday interview at 4:10 Pf stated "I don't wan be o.k. to have a standard the it if my daughter doctors and I told the interview on 07/19/confirmed that the contiled to accompleted to accomplete the accompleted to accomplete the accomplete that the accomplete t	PM, a family member stated, at I should bring in clothes I didn't know I needed to, wer went to the doctors or h so I wasn't sure what to do". was also upset that staff did esident #129] was going to the and that s/he was afraid. Per M on 07/19/11, the resident to be a burden, but it would have and to get a shirt on n't know how things work also stated that "I would really or comes with me to the nem that when I got here". Per 11 at 4:30 PM the Unit Nurse comprehensive care plan was didress all identified needs.	F 278			
	The services provide must meet profession	ted or arranged by the facility onal standards of quality.				
	by: Based on interview falled to meet profe regarding administr or obtaining, followi physician orders for	NT is not met as evidenced rand record review, the facility ssional standards of quality ation of expired medications ng, and documenting 2 of 17 residents in the Stage ts #8, #56). Findings include:				
	Administration Reconstruction Nephro-Vit is written	w of the MAR (Medication ord) for Resident #56, n as to be given at 8:00 PM, n order was written to be given				

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FAX NO. 8022412358

P. 07/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/04/2011 FORM APPROVED

						Other Mo	2000 000
STATEMENT	of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
			Th. 1201	-Mild			
	·	475020	8, WIN	IG		07/20	/2011
NAME OF P	ROVIDER OR SUPPLIER			BTR	EET ADDRESS, CITY, STATE, ZIP CODE		1
DCD) IN	CEALWIS DELIAB A	TO.		96	HOSPITALITY DRIVE		
BERLIN	HEALTH & REHAB C	E PC		В	ARRE, VT 05641		
D(4) ID	SUMMARY BTA	TEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION BHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD SE ROPRIATE	COMPLETION DATE
					Corrective action:		·
F 281	Continued From pa	ige 4	· F:	281	F 281		
	,	terview on 07/20/11 at 3:00		- 1	1. Resident #8 and #56 we	ere Te	
		stated that the medication		1	evaluated no negative o	•	
		ause the resident requested It"		- 1	resulted from this allege		
	and confirmed that	the physician was not notified			practice.		
	of the time change	for this medication. In		- 1	2. Resident #56 physician	vas.	
		10 mg (milligrams), Ranexa		- 1	contacted and order rec		
		led release), and Morphine		- 1	administer medications		
		nanged from 6:00 PM to 8:00			times per resident reque	est	
		ager confirmed on 07/20/11 at		ļ	Resident #8 medication		
		are no orders for the time		;	discarded immediately.		
	changes for admin	Istration of these medications.		į	3. All residents receiving		i
	1			į	and those residents rece		
	3 Por abconcilor	Interview, and record review,		i	medications that require		
	Resident #8 receiv			i	refrigeration are at risk.		· .
		expired and staff falled to		1	4. Re-educate licensed nu		
		tration of 2 doses of that			regarding proper admin		
		n orders written for Resident #			medications and obtaining		ļ
•		nycin [antibiotic] 5 milliliters			physician orders.	Ü	
	[125 milligrams] Pt	O [by mouth] daily until 6/20/11.			5. Random weekly audits	to be	
		14 days, then every 3 days for			performed by Director of		
		weekly for 14 days, then			or designee to determin		
	1	observation of the medication			compliance with plan.		
	storage room on 'A	wing', both bottles of liquid			6. Director of Nursing or o	lesignee	
	vancomycin iabaia	d for Resident #8 were			shall report out to QAA	committee	
	6/24/11 Per inten	ation dates of 6/19/11 and /law on 7/20/11 at 2:45 PM, the			monthly x3 at this time	frequency	
		immed that both bottles were			of further surveillance s	hall be	j
		n date. Resident #8 received			determined by committe		
		he medication after the dates			7. Corrective actions shall	be	
		review of the Medication			complete by 8/20/2011		
Ì		ord (MAR), doses due on					_
		were not documented as		٠i	ENGI POC SARAN	A 111	18/11
l		d. Per interview on 7/20/11 at		1	F281 POC accept Karen Camp	m 011	0 1)
1	2:45 PM, the Unit I	Manager [UM] confirmed that			V. C.	201	
[the doses due per	physician's order on 7/8/11			talen lamp	or ku	
		not initialed as given on the					
I	MAR,						I

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FAX NO. 8022412358

P. 08/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 08/D4/2011 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475020	B. WIN	NG_		07/20/2011	
	ROVIDER OR SUPPLIER	TR		91	REET ADDRESS, CITY, STATE, 2IP CODE 8 HOSPITALITY DRIVE BARRE, VT 05841		
(X4) ID PREFIX TAG	(EACH DEPICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ULD BE	COMPLETION DATE
F 281	Continued From pa	ge 5	F	281			
F 282 SS¤D	Drug Handbook, pg 2. Lippincott Manua Wolters Kluwer Hez Wilkins, pg 17. 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provide must be provided by accordance with ea care. This REQUIREMEN by: Based on observat interview, the facility according to the car the Stage 2 sample Findings include: 1. Per observations Resident #92 remai being repositioned of hours. Per continuo from 9:15 AM until observed in the san 45 degrees, and wit the hallway near the not offer to repositio or after the meal. F from 9:15 AM -11:1 the gerl-chair with la review, the care pla	I of Nursing Practice (9th ed.), alth/Lippincott Williams & RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of the resident's written plan of lon, record review and y failed to provide services re plan for 2 of 17 residents in (Residents #92, #183) son 67/19/11 and 07/20/11, and in a gerl-chair without or tolleted for greater than 3 aus observation on 07/19/11 12:15 PM, the resident was ne position with the legs up at the position with the legs up at the position with the legs up at the main dining room. Staff did an or toilet the resident prior to the resident #92 was in legs elevated. Per record	F	282	Corrective action: F 282 1. Resident #92 and #183 evaluated no negative or resulted from this allege practice. 2. Resident #92 care plant adjusted to meet the resident #183 miticket error was corrected dietary preferences reviupdated on care plan. 3. All residents requiring a with repositioning and repreferences/special dietare at risk. 4. Re-educate licensed nurregarding monitoring explanes of all medications educate dietary staff on card accuracy. 5. Random weekly audits performed by Director of and Dietary Manager of to determine continued with plan. 6. Director of Nursing and Manager or designee shout to QAA committee at this time frequency of surveillance shall be decommittee. 7. Corrective actions shall complete by 8/20/2011	autome ed deficient was ident's ident's ident's ideal tray ed and ewed and assistance nutritional s'allergies res expiration i. Re- diet tray to be of Nursing r designee compliance d Dietary iall report monthly x3 if further termined by	

AUG-U4-2011 THU U3:15 PM LICENSING AND PROTECTION

FAX NO. 8022412358

		AND HUMAN SERVICES		PRINTED: FORM A	PPROVED		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE BUI COMPLET	RVEY
		475020	B, WING	·		07/20	/2011
	ROVIDER OR SUPPLIER	TR		38 H	TADDRESS, CITY, STATE, ZIP CO OSPITALITY DRIVE RRE, VT 05641	DDE	,
(X4) ID · PREFIX TAG	PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL		PREFU TAG	ζ .	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REPERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 282	resident requiring mobility and requir transfers, Resident changed before at care). Per the LN list care plan, Resevery 2 hours and check and changed Per interview on 0 stated "I got [Resiwashed, served be nursing station, and dining room, and care". S/he confirmed for provided as care plan dated 5 allergies to tomes the medical diag a histal hernia and reflux disease). Fervice at 5:00 P tray contained a bread and tomate Resident #183 in tomato soup per review of the dies that Resident #184.	extensive assist for bed ing a mechanical lift for it #92 is to be checked and after meals (incontinence A (Licensed Nursing Assistant) ident #92 is to be repositioned states to offer a urinal or to a before and after meals 17/20/11 at 2:00 PM the LNA dent #92] up around 7-ish, reakfast, sat in chair near and then out in hallway near just now did the incontinence in the that on 7/20/11 Resident sitioned for greater than two and changed before and after Manager at 2:15 PM on eat that care and services were are planned for this resident. Allow on 7/18/11 of the nutritional idea and pineapple. Review of all indicated that Resident #183 noses of recent surgical repair of the GERD (gastro esophageal for observation of the meal M on 7/18/11, Resident #183's harm salad sandwich on white a soup. Per interview on 7/18/11, dicated that s/he was not to have physician's instructions. Per tary slip on the tray, it indicated and fruit and is not to have and fruit and is not to have	F	82			

AUG-04-2011 THU 03:15 PM LICENSING AND PROTECTION

FAX NO. 8022412358

P. 10/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/04/2011 FORM APPROVED OMB NO. 0888-0391

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XZ) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		475020	BL WIN	۰ س		07/20	/2011
•	ROVIDER OR SUPPLIER HEALTH & REHAB C		,	98	CET ADDRESS, CITY, STATE, ZIP CODE I KOBPITALITY DRIVE ARRE, VT 05641		
(X4) ID PREFIX TAG	Bunmary Statement of Depiciencies (Each Depiciency must be preceded by Full Regulatory or LSC (Dentifying Information)		(D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG ORDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(KS) COMPLETION DATE
F 282 F 309 8S=0	On 7/18/11 at 6:30 Dietary Service Ma Registered Dieticia menu and substitut chicken noodle. The servers had not resistems on Resident the District Managarallergic reactions a adhering to the residenters. 483.25 PROVIDE HIGHEST WELL E Each resident mus provide the necess or maintain the highental, and psych accordance with the	PM, during interview with the inager (DSM) and the in (RO), they had changed the ted tomato soup for the led tomato soup for the led tomato soup for the led the ticket when placing the #183's tray. The RD, DSM and ar confirmed the potential for and medical issues from not cident's dietary restrictions was		309	#282 POC accep Karen Campo	ted 8/18/11 2 PN	
	by: Based on Intervie failed to provide the to ensure each respracticable physics resident in the same worsening of a wollnclude: 1. Per record reviadmitted on 7/1/11 his/her left ankle. "assessment" of the same same same same same same same sam	w and record review, the facility re necessary care and services sident maintains the highest al well-being for 1 applicable uple regarding the avoidable und. (Resident #193) Findings ew, Resident #193 was I with a scabbed area on The only documented his wound was a circled left agram, an indication that it was					

HUG-U4-ZUII THU U3:15 PM LICENSING AND PROTECTION

FAX NO. 8022412358

11/16

DEPARTMENT	OF HEALTH AND	HUMAN	SERVICES
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PRINTED: 08/04/2011 FORM APPROVED OMB NO: 0908-0304

BTATEMEN	T OF DEPICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	IULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		475020	B. WI	NG		07/20/2011	<u> </u>
	PROVIDER OR SUPPLIER HEALTH & REHAB C	TR		96	EET ADDRESS, CITY, STATE, ZIP COD I MOSPITALITY DRIVE ARRE, VT 05641	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	1X	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REPERENCED TO THE DEFICIENCY)	SHOULD BE COMP	US) LETION LTE
F 309	a scab, and a mea (centimeters). The assassment as to the wound was, where lated to an Impacause. There was regarding the wound for surrounding ties of the Treatment / there was no documented wound admission. On the "Intact akin" on 2 of frame of 13 days ware 2 additional wound that the residucumented treatment of 13 days wound, dated 7/12 surrounding the hankle is pink and condition report, ankle wound mean increase in size signesence of sloug tissue separated the wound bed, and the edges. A woundicated that the with slough", "tendordar is red", and consult. The wound Resident #193 has feet and the feet consult recomme ordered until 7/19	surement of 0.7 cm ere was no documented what the underlying cause of mether is was pressure related, imment in circulation, or other in the documented assessment and edges, shape, or condition these on admission. Per review administration Record (TAR), immentation of any treatment to and for a period of 12 days after of TAR, licensed staff indicated accasions during the same time since admission, when there wounds other than the left ankle sident was receiving		309	Corrective action: F 309 1. Resident #193 was negative outcomes alleged deficient properties of the properties of the properties of the physician on 7/1 further vascular con 7/19/11 the physician on 7/20 family was declined interventing Resident #193 was Certified Wound Cand noted improve Physician assessed again on 7/25/11. 3. All residents with 4. Re-educate license regarding ulcer assessed again on designee to continued compliant of designee to continued compliant of further surveilled determined by con 7. Corrective actions complete by 8/20/19	from this ractice. assessed on d Wound faxed requested 4 and 7/15 for insult. On ian requested the family first, is consulted and ions. On 7/21/11 is assessed by Ostomy Nurse ement of wound. I resident #193 ulcers are at risk. It is a consulted and ions of the family first, is consulted and ions. On 7/21/11 is assessed by Ostomy Nurse ement of wound. I resident #193 ulcers are at risk. It is a consulted and in the family family for the family family family for the family family for the family	

FAX NO. 8022412358

P. 12/16

PAGE 11/15

PRINTED: 08/04/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES.... 48 NO. 0039 0301 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 475020 07/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS; CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BERLIN HEALTH & REHAB CTR **BARRE, VT 05641** (X4) ID BUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 9 F 309 deep redness surrounding the area, the wound bed has yellow green slough in the center, and the resident voiced tenderness during the dressing change. During interview on 7/20/11 at 9:30 AM, the Unit Manager confirmed that the left ankle wound had deteriorated in the period from admission to the F309 Poc accepted 8/18/1 Raien Campoz RN wound consult on 7/14/11, nurses documented skin as intact on the TAR while the resident had open wounds, and confirmed that the physician consult was not ordered until 5 days after the recommendation was made by the wound nurse. During Interview on 7/20/11 at 11:06 AM, the Director Of Nursing confirmed that Resident #193 was not seen on weekly interdisciplinary wound rounds until 7/14/11, and confirmed that the Resident was admitted with open wounds. F 371 483.35(i) FOOD PROCURE, F 371 STORE/PREPARE/SERVE - SANITARY

SS≖D

The facility must -

- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities: and
- (2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced bv:

Based on observation and staff interview, the facility falled to assure that distary staff stored. prepared, and served foods under sanitary conditions in accordance with acceptable safe

Event ID: RMBH11

Facility ID: 475020

if continuation sheet Page 10 of 14

AUG-U4-2011 THU U3:16 PM LICENSING AND PROTECTION

FAX NO. 8022412358

P. 13/18

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PERMI	• • • • • • • • • •	AND HUMAN SERVICES			
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A BUIL	DING	OCIVII LL I PP
		475020	B. WING	3	07/20/2011
AME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE	E, ZIP CODE
BERLIN I	HEALTH & REHAB C	TR	98 HOSPITALITY DRIVE BARRE, VT 05641		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	(D PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE DAT
F 371	food handling practices of tour on 7/18/11 at areas/practices were a. Per observation dishwashing sink, the second compathe Food Service AM, the pans had When teated by the for adequate amough sanitizer to the Food Service reading, and the seanitation process.	tices. Findings include: In the kitchen during the initial 10:10 AM, the following are noted: To of the 3 bay manual several pans were in water in intrment and per interview with Manager on 7/18/11 at 10:10 been soaking since 5:45 AM. The Food Service Manager (FSM) unts of sanitizer in the water, ealed the water did not contain to be be be a contained the interview as drained and the crestarted. To of the dry goods storage area,	F 3	F 371 1. Issues ident and dining on negative alleged defi sanitation primmediately was dispose 7/18/11. Its on 7/18/11. Its on 7/18/11. Its of 1/18/11. St dining room immediately and sanitation of the center and sanitation of the center and sanitation of the center and sanitation.	ified on kitchen tour observations resulted in outcomes from this cient practice. It sink was drained and rocess was restarted on 7/18/11. Item B and of immediately on om C were disposed of Item D, steam table I and refilled on om E was disposed on affs observed in the of were re-educated by on hand washing. It that consume meals at one at risk. dietary staff on proper
	was observed to the shelf and not under confirmed that the refrigerated after conservation frosted cake were kitchen. The FSM and were to be different and food downster and food downster had a "rust service cook indicaturned on at 5:30	n, eight pieces of unlabeled a stored on the metal rack in the i confirmed they were not dated sposed of today. on, the hot steam table contained abris (rice) in the bottom and the y" appearance to it. A food cated that the steam table was AM and it was to be drained		storage, pre food under educate star room about 5. Random we performed and Dietary to determin with plan. 6. Director of Manager of out to QAA at this time surveillanc committee.	paration and service of sanitary conditions. Reff assisting in the dining proper hand washing. Eachly audits to be by Director of Nursing Manager or designee to continued compliance. Nursing and Dietary designee shall report a committee monthly x3 frequency of further e shall be determined by
		htty. The FSM confirmed at efficient was from the dinner		•	actions shall be

complete by 8/20/2011

HUG-U4-ZUII 1HU U3:16 PM LICENSING AND PROTECTION

FAX NO. 8022412358

P. 14/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/04/2011 FORM APPROVED: 0304 0304

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE BURVEY COMPLETED	
		475020	B. WING		07/20/2011	
	ROVIDER OR SUPPLIER HEALTH & REHAB C	TR	s	TREET ADDRESS, CITY, STATE, ZIF COD 98 HOSPITALITY DRIVE BARRE, VT 05641	E	
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 371	e. Per observation pound bag of molecoler floor. The fill molecular floor is molecular floor. The fill molecular floor f	fore and that the steam table	F 37	F371 Poc acc Karen Campi	epted 8/18/ 02 RN	l
F 431 8S=0	b. Per observation 7/18/11, Staff #1 versidents and was touching residents assisting with table residents. During sanitize her hands the staff member sanitize hands be didn't have any said 483,60(b), (d), (e)	n in the main dining room on was observed feeding two helping with hand held foods, hands and shoulders and eware and food dropped by the this time s/he did not glove or During interview at 4:45 PM, stated that s/he would normally tween resident contacts but anitizer at the table. DRUG RECORDS, FRUGS & BIOLOGICALS	F4	J31		

FAX NO. 8022412358

P 15/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/04/2011 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR O(A) ID PREPIX (EACH DEPICIENCY MIST BE PROCEDED BY FULL TAG (EACH DEPICIENCY) F 431 Continued From page 12 The facility must employ or obtain the services of a licensed phermacial who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconcillation; and determinate that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in lacked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit	STATEMENT	OF OFFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER BERLIN HEALTH & REHAB CTR MAID SUMMARY STATEMENT OF DEPICIENCIES BARRE, VT 05841 MAID REGULATORY OR Lac DEPTICIENCIES CEACH DEPTICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR Lac DEPTICIENCY F 431 Continued From page 12 The facility must employ or obtain the services of a licensed pharmaciat who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconcilided. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and caultonary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in liceked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to a buse, excapt when the facility uses single unit			475020	-			07/20	1/2044
### BERLIN HEALTH & REHAB CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL TYPE AND FEDERAL DEFICIENCY WIST BE PRECEDED BY FULL TYPE AND FEDERAL DEFICIENCY) F 431	NAME OF P	ROVIDER OR SUPPLIER	773020		STR	EET ADDRESS, CITY, STATE, ZIP CODE	01120	3/2011
F 431 Continued From page 12 The facility must employ or obtain the services of a licensed pharmaciat who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments to storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit	BERLIN I	HEALTH & REHAB C	TR .		98	B HOSPITALITY DRIVE		
The facility must employ or obtain the services of a licensed phermaciat who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is meintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SI)O CROSS-REFERENCED TO THE APPR	ULD BE	(XB) COMPLETION DATE
package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications FH31 POC accepted **Even Campon FU **Laven	F 431	The facility must are a licensed pharmac of records of receip controlled drugs in accurate reconciliar records are in order controlled drugs is reconciled. Drugs and biological labeled in accordary professional principal appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and permit have access to the The facility must propermanently affixed controlled drugs is Comprehensive Drugs drugs drug distructional act of 1976 abuse, except whe package drug distructional detected. This REQUIREME by: Based on observations are allocated on observations.	nploy or obtain the services of sist who establishes a system of and disposition of all sufficient detail to enable an atom; and determines that drug r and that an account of all maintained and periodically als used in the facility must be not with currently accepted ales, and include the cory and cautionary expiration date when state and Federal laws, the all drugs and biologicals in into under proper temperature it only authorized personnel to keys. Tovide separately locked, discompartments for storage of ted in Schedule II of the rug Abuse Prevention and and and other drugs subject to an the facility uses single unit ibution systems in which the ninimal and a missing dose can limit. NT is not met as evidenced tion, interview, and record	F	431	Corrective action: F431 1. Resident #8 was assess negative outcomes from alleged deficient practical actions immediately discarded. 2. Resident #8 medication immediately discarded. 3. All residents that receis medications that require refrigeration are at risk. 4. Re-educate licensed management in regarding proper admin medications. 5. Random weekly audits performed by Director and or designee to detect continued compliance. 6. Director of Nursing or shall report out to QA monthly x3 at this time of further surveillance determined by comming the complete by 8/20/201	n this ice. n was ve re c. urses nistration of s to be of Nursing ermine with plan designee A committe e frequency shall be ntee. ill be l	e

AUG-U4-2011 THU U3:16 PM LICENSING AND PROTECTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HAX NU. BUZZ41Z358

P. 10/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLER/CLIA DENTIFICATION NUMBER:		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X9) DATE SURVEY COMPLETED 07/20/2011		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE				
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	²)X	RRE, VT 06641 PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(XE) COMPLETION DATE	
F 431	were discarded af 17 residents in the Findings include: 1. Per observation medication refrige facility contained a Vancomycin (antilexpiration date of of Vancomycin for date of 6/24/11. I Medication Admir resident was schediven every 3 day now to receive it interview on 7/20.	age 13 ter the expiration dates for 1 of a Stage 2 sample (Resident #8). If on 7/20/11 at 2:00 P.M. the frator located on 'A wing' of the circle for Resident #8 with the 6/19/11, and one 200 ml. bottle r. Resident #8 with the expiration Record [MAR], the eduled for the Vancomycin to be store weekly for 2 weeks, and was once weekly for 2 weeks. Per //11 at 2:45 PM, the A wing Unit		431				
	Manager (OM) oc Vancomycin were dates.	e in use past their expiration						



Berlin Health and Rehabilitation Center

98 Hospitality Drive Barre, VT 05641

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